

F. RFP QUESTIONNAIRE

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GENERAL INFORMATION

1. State the full name of your organization and describe its services and structure, including your main and branch offices, how long you have been in business and your average number of full-time employees.
2. Provide the name, title, address, phone number and email address of the contact person for this RFP.
3. Provide the states in which your organization is licensed to provide the services requested in this RFP.
4. Provide the location from which you plan to service this account.
5. The Department requires that the TPA vendor shall cooperate with all other contractors of the Department in the on-going coordination and delivery of Department services and in any transfer of responsibility. Confirm you will comply with this requirement.
6. Does your proposal assume a joint venture with other organizations? If so, specify your role and those of the other organizations. Which organization would be responsible for overall account management and direction?
7. Provide the experience requirements of the Claims Manager, claims adjusters and any supervisory and/or support personnel who will be assigned to this contract. If you have already identified a specific claims manager, include a resume of this person.
8. The Department reserves the right to audit all records maintained by the TPA vendor and/or its affiliates relative to the TPA vendor's performance under this contract. At least 48 hours notice will be given to the vendor of the intent to audit. The Department shall have the right to perform financial, performance and other special audits on such records maintained by the TPA vendor during regular business hours throughout the contract period. The TPA vendor agrees that confidential information including, but not limited to, medical and other pertinent information relative to employees of the Department, shall not be disclosed to any person or organization for any purpose without the express, written authority from the Department. The selected TPA vendor will make available all records, as defined by the

selected auditor, for review at no cost to the Department. Indicate your acceptance of this proposal requirement and willingness to cooperate. Any ancillary fees that may be assessed to the Department for on-site audits should be included in your proposal fee for administrative services.

9. Has your organization ever been involved in a lawsuit involving any area covered by this RFP? If yes, provide details including dates and outcomes.
10. During the past five (5) years has your organization or any employees been a party in any material criminal litigation, whether directly related to this RFP or not? If so, provide details including dates and outcomes.
11. References (The Department reserves the right to request additional references)
  - a. List at least three (3) TPA clients who can serve as references. For each reference, provide a contact name, full address, phone number and email address.
  - b. List the time period TPA service has been provided to each client and the average number of employees for each client.
12. Assuming notification of your selection as the TPA on or before May 2, 2016, how do you propose to organize the transition and implementation schedule for a contract effective date of August 1, 2016. Provide an implementation chart outlining the specific tasks required, actions involved, the responsibilities of all parties during each phase and the corresponding dates.

#### CLAIMS ADMINISTRATION SERVICES

13. For claim services provided by the office that will service the program, provide the following workers' compensation data your system captures this data on all clients (in total, not client specific), for 2015 calendar year.
  - a. Average number of days from date lost time claim was reported to the date claimant was contacted
  - b. Average length (in days) of disability per claim (exclude medical only)
  - c. Average paid medical cost per claim
  - d. Average indemnity cost per claim
  - e. Average number of days to pay medical bills on non-controverted claims
  - f. Maximum number of open lost time files handled by an adjuster
  - g. Number of times the Workers' Compensation Commission notified you of untimely filing of MWCC forms
14. Explain your firm's medical cost containment program, describing each service in detail. In addition, restate each service listed below and state whether your firm currently performs the service in-house or contracts with an outside firm. If a contractual agreement exists, provide the name and physical location of the firm provident each service and include a brief description of the nature and length of your relationship with each listed service provider.

- a. Fee Schedule Review
- b. Hospital Bill Review
- c. Inpatient Pre-certification
- d. Outpatient Pre-certification
- e. RN Telephonic Case Management
- f. Utilization Review
- g. Physical Therapy Pre-certification
- h. Occupational Therapy Pre-certification
- i. Pharmacy benefit management

Provide information on any other services you may offer that are not listed above. The Department reserves the right to select or reject any, all or none of the services discussed in this section.

15. Describe in detail how your organization proposed to load and maintain all the Department's claims date from the prior TPA for all claims, open and closed, in a manner to ensure consistency in claims data reporting. This shall include your plan to re-number/re-catalog all claim files or maintain the current claim file numbers on transferred open and closed claims.
16. Provide a written statement detailing your firm's understanding of the services requested herein as well as a detailed written plan outlining how your company proposes to provide the services required by this RFP.
17. Provide your organization's written procedures documenting the security and off-site storage of all data contained on tapes, discs, files, batch files and other records pertinent to the TPA services to be provided to and on behalf of the Department. Include a brief description of your disaster recovery plan to demonstrate how you will recover lost data and utilize alternate resources to operate in the event of such an occurrence.
18. Provide examples of reports that meet the Department's needs in tracking claims costs of the program. Provide an example of a narrative report recommending settlement of a claim.
19. Complete the COST QUOTATION FORM (Section D). Please note that the Department prefers guaranteed flat bundled fee for claims administration services and will not accept a fee based on a percentage of payroll, number of claims or any other variable statistic. As the contract the Department proposes to award as a result of this RFP will be four years with a one year extension option please provide fee quotations for each of the five years listed.
20. The Department requires that administrative and medical cost containment fees be fully guaranteed for the term of the contract. Confirm that you agree to comply with this requirement.

21. Indicate your willingness to guarantee a return on investment (ROI) for any of the medical cost containment services. Describe how any proposed ROI would be measured.
22. Confirm that your rates include maintaining a toll-free telephone number for calls from claimants and employers.
23. Confirm your understanding of and agreement to the duties and responsibilities listed in Section A. Claims Administration Services. Note any objections/exceptions you have to any of the listed items.